# DESCRIPTION OF FEDERAL TAX RULES AND LEGISLATIVE BACKGROUND RELATING TO LONG-TERM CARE

Scheduled for a Public Hearing

before the

SENATE COMMITTEE ON FINANCE

on March 27, 2001

Prepared by

the Staff of the

JOINT COMMITTEE ON TAXATION

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## INTRODUCTION

The Senate Committee on Finance has scheduled a public hearing on March 27, 2001, on issues relating to long-term care.

This document,[1] prepared by the staff of the Joint Committee on Taxation, contains a description of present law Federal tax provisions and legislative background relating to long-term care services and contracts.

[1] This document may be cited as follows: Joint Committee on Taxation, *Description of Federal Tax Rules and Legislative Background Relating to Long-Term Care* (JCX-18-01), March 26, 2001.

## I. PRESENT LAW FEDERAL TAX RULES RELATING TO LONG-TERM CARE

### A. In General

Present law provides favorable tax treatment for qualified long-term care insurance contracts and qualified long-term care services. This treatment is similar to the favorable tax treatment that applies to medical insurance and services and employer-provided accident or health plans.

In general, amounts received under a qualified long-term care insurance contract are excludable from income (subject to an annual dollar cap in the case of per diem contracts[2]). Employer contributions for qualified long-term care insurance are excludable from income, except that this exclusion does not apply to long-term care insurance or services provided under a cafeteria plan or flexible spending arrangement. Up to certain dollar limits, premiums for qualified long-term care insurance are treated as a medical expense for purposes of the itemized deduction for medical expenses, and are deductible under the rules relating to deduction of health insurance expenses for self-employed individuals. Expenses for qualified long-term care services are treated as medical expenses for purposes of the itemized deduction for medical expenses.

### B. Exclusion from Gross Income of Proceeds Under Long-Term Care Insurance Contracts

Amounts (other than policyholder dividends or premium refunds) received under a qualified long-term care insurance contract generally are excludable from income, subject to a dollar cap in the case of per diem contracts. Long-term care benefits in excess of the annual dollar cap under per diem contracts are includible in gross income.

The amount of the dollar cap with respect to any one chronically ill individual is $200 per day or $73,000 annually (for 2001), reduced by the amount of reimbursements and payments received by anyone for the cost of qualified long-term care services for the chronically ill individual. If more than one payee receives payments with respect to any one chronically ill individual, then everyone receiving periodic payments with respect to the same insured is treated as one person for purposes of the dollar cap. The amount of the dollar cap is utilized first by the chronically ill person, and any remaining amount is allocated in accordance with Treasury regulations. If payments under such contracts exceed the dollar cap, then the excess is excludable only to the extent of actual costs (in excess of the dollar cap) incurred for long-term care services. Amounts in excess of the dollar cap, with respect to which no actual costs were incurred for long-term care services, are fully includible in income.

The $200 per day limit is indexed for inflation.

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[2] Per diem contracts are contracts that provide payment on a daily or other periodic basis without regard to expenses incurred during the period.

### C. Deductibility of Long-Term Care Services and Premiums for Long-Term Care Insurance

Present law provides that unreimbursed medical expenses, including expenses for medical insurance, are deductible as an itemized deduction to the extent the taxpayer's total of such expenses exceeds 7.5 percent of adjusted gross income ("AGI"). Unreimbursed expenses for qualified long-term care services provided to the taxpayer or the taxpayer's spouse or dependents and, within limits, premiums for qualified long-term care contracts are treated as medical expenses for purposes of this itemized deduction. Amounts received under a qualified long-term care insurance contract (regardless of whether the contract reimburses expenses or pays benefits on a per diem or other periodic basis) are treated as reimbursement for expenses actually incurred for medical care and, thus, are not taken into account in determining the amount of deductible medical expenses.

The maximum amount of long-term care insurance premiums that can be taken into account for purposes of the itemized deduction for medical expenses cannot exceed the following limits (for 2001):

The limitation on premiums paid for such taxable years is:

| **In the case of an individual with an attained age before the close of the taxable year of:** | **The limitation on premiums paid for such taxable years is:** |
|---|---|
| Not more than 40 | $ 230 |
| More than 40 but not more than 50 | 430 |
| More than 50 but not more than 60 | 860 |
| More than 60 but not more than 70 | 2,290 |
| More than 70 | 2,860 |

These dollar limits are indexed for inflation.

### D. Deduction for Long-Term Care Insurance of Self-Employed Individuals

Self-employed individuals may deduct 60 percent of their premiums on qualified long-term care insurance contracts covering themselves or their spouse or dependents for 2001. The amount of premiums that can be taken into account for purposes of the deduction is limited to the maximum premium treated as a medical expense under the itemized deduction for medical expenses, described above. The deductible percentage of qualified long-term care insurance premiums of self-employed individuals increases to 70 percent for taxable years beginning in 2002, and to 100 percent for taxable years beginning in 2003 and thereafter.

The deduction for qualified long-term care insurance expenses of a self-employed individual is not available for a month for which the individual is eligible to participate in any

subsidized long-term care plan maintained by any employer of the individual or the individual's spouse.

### E. Treatment of Employer-Provided Long-Term Care Coverage

A plan of an employer providing coverage under a qualified long-term care insurance contract generally is treated as an accident or health plan. Thus, employer contributions for qualified long-term care insurance for the employee, his or her spouse, and his or her dependents are excludable from gross income and from wages for employment tax purposes. This exclusion does not apply, however, to employer-provided coverage provided through a cafeteria plan.[3] Similarly, employee expenses for long-term care services cannot be reimbursed under a flexible spending arrangement on a tax-free basis.[4] Amounts received from long-term care insurance purchased by the employer are excludable from income (subject to the cap on per diem contracts).

Employer contributions for long-term care insurance are deductible by the employer as a trade or business expense.

A group health plan under which substantially all of the coverage is for qualified long-term care services is not subject to the continuation health care coverage rules.[5]

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[3] A cafeteria plan is an arrangement under which employees are given the option of receiving cash or certain nontaxable benefits, such as health insurance coverage or dependent care. If certain requirements are satisfied, the employee is not required to include the amount of cash offered in income unless the employee actually elects to receive the cash. Sec. 125.

[4] A flexible spending arrangement ("FSA") is a reimbursement account or other arrangement under which an employer pays or reimburses employees for medical expenses or certain other nontaxable benefits, such as dependent care. An FSA may be funded by direct employer contributions, or may be funded by employee salary reduction contributions through a cafeteria plan. FSAs are commonly used, for example, to reimburse employees for medical expenses not covered by the employee's insurance (e.g., expenses below the deductible amount under the employee's insurance). While long-term care expenses cannot be reimbursed under a FSA (or provided through a cafeteria plan), if certain requirements are satisfied, under present law, individuals may be able to exclude amounts paid by an employer through an FSA or cafeteria plan for certain work-related expenses relating to the care of dependents who are physically or mentally incapable of caring for themselves. Sec. 129.

[5] The health care continuation rules generally require a group health plan to provide qualified beneficiaries who would otherwise lose coverage under the plan due to termination of employment or certain other events to elect to continue to participate in the plan. Within limits, the plan is permitted to charge for such continuation coverage. Sec. 4980B.

## F. Consumer Protection Provisions

Qualified long-term care insurance contracts, and issuers of such contracts, are required to satisfy certain provisions of the long-term care insurance model Act and model regulations promulgated by the NAIC (as adopted as of January 1993).

The contract requirements relate to disclosure, nonforfeitability, guaranteed renewal or noncancellability, prohibitions on limitations and exclusions, extension of benefits, continuation or conversion of coverage, discontinuance and replacement of policies, unintentional lapse, post-claims underwriting, minimum standards, inflation protection, preexisting conditions, and prior hospitalization. Disclosure and nonforfeiture requirements also apply. The nonforfeiture provision gives consumers the option of selecting reduced paid-up insurance, extended term insurance, or a shortened benefit period in the event a policyholder who elects a nonforfeiture provision is unable to continue to pay premiums. The requirement that insurers offer policyholders a nonforfeiture benefit does not preclude the imposition of a reasonable delay period. The consumer protection provisions that apply with respect to the terms of the contract apply only for purposes of determining whether a contract is a qualified long-term care insurance contract.

The requirements for issuers of long-term care insurance contracts relate to application forms, reporting requirements, marketing, appropriateness of purchase, format, delivering a shopper's guide, right to return, outline of coverage, group plans, policy summary, monthly reports on accelerated death benefits, and incontestability period. A tax is imposed equal to $100 per insured per day for failure to satisfy these requirements. The consumer protection requirements for issuers of contracts apply with respect to contracts that are qualified long-term care insurance contracts.

An otherwise qualified long-term care insurance contract will not fail to be a qualified long-term care insurance contract solely because it satisfies a consumer protection standard imposed under applicable State law that is more stringent than the analogous standard provided in the Code.

## G. Life Insurance Company Reserves

In determining reserves for insurance company tax purposes, the Federal income tax reserve method applicable for a long-term care insurance contract issued after December 31, 1996, is the method prescribed by the NAIC (or, if no reserve method has been so prescribed, a method consistent with the tax reserve method for life insurance, annuity or noncancellable accident and health insurance contracts, whichever is most appropriate). In no event may the tax reserve for a contract as of any time exceed the amount which would be taken into account with respect to the contract as of such time in determining statutory reserves.

## H. Definitions

### 1. Qualified long-term care insurance contract

**In general**

A qualified long-term care insurance contract is defined as any insurance contract that provides only coverage of qualified long-term care services and that meets other requirements. The other requirements are that (1) the contract is guaranteed renewable, (2) the contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged or borrowed, (3) refunds (other than refunds on the death of the insured or complete surrender or cancellation of the contract) and dividends under the contract may be used only to reduce future premiums or increase future benefits, (4) the contract generally does not pay or reimburse expenses reimbursable under Medicare (except where Medicare is a secondary payor, or the contract makes per diem or other periodic payments without regard to expenses), and (5) the contract satisfies the consumer protection requirements described above.

A contract does not fail to be treated as a qualified long-term care insurance contract solely because it provides for payments on a per diem or other periodic basis without regard to expenses incurred during the period.

**State-maintained plans**

An arrangement is treated as a qualified long-term care insurance contract if an individual receives coverage for qualified long-term care services under a State long-term care plan, and the terms of the arrangement would satisfy the requirements for a long-term care insurance contract under the provision, were the arrangement an insurance contract. For this purpose, a State long-term care plan is any plan established and maintained by a State (or instrumentality of such State) under which only employees (and former employees, including retirees) of a State or of a political subdivision or instrumentality of the State, and their relatives, and their spouses and spouses' relatives, may receive coverage only for qualified long-term care services. "Relative" is defined as under section 152(a)(1)-(8).

**Long-term care riders on life insurance contracts**

In the case of long-term care insurance coverage provided by a rider on or as part of a life insurance contract, the requirements applicable to qualified long-term care insurance contracts apply as if the portion of the contract providing such coverage were a separate contract. The term "portion" means only the terms and benefits that are in addition to the terms and benefits under the life insurance contract without regard to long-term care coverage. As a result, if the applicable requirements are met by the long-term care portion of the contract, amounts received under the contract as provided by the rider are treated in the same manner as long-term care insurance benefits, whether or not the payment of such amounts causes a reduction in the contract's death benefit or cash surrender value. The guideline premium limitation applicable under section 7702(c)(2) is increased by the sum of charges (but not premium payments) against the life insurance contract's cash surrender value, the imposition of which reduces premiums paid for the contract (within the meaning of sec. 7702(f)(1)). In addition, it is anticipated that Treasury regulations will provide for appropriate reduction in premiums paid (within the

meaning of sec. 7702(f)(1)) to reflect the payment of benefits under the rider that reduce the cash surrender value of the life insurance contract.

**2. Qualified long-term care services**

Qualified long-term care services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services that are required by a chronically ill individual and that are provided pursuant to a plan of care prescribed by a licensed health care practitioner. Maintenance and personal care services may include meal preparation, household cleaning, and other similar services which the chronically ill individual is unable to perform.

For purposes of the deduction for medical expenses, qualified long-term care services do not include services provided to an individual by a relative or spouse (directly, or through a partnership, corporation, or other entity), unless the relative is a licensed professional with respect to such services, or by a related corporation (within the meaning of Code section 267(b) or 707(b)).

A chronically ill individual is one who has been certified within the previous 12 months by a licensed health care practitioner as (1) being unable to perform (without substantial assistance) at least 2 activities of daily living for at least 90 days due to a loss of functional capacity, (2) having a similar level of disability as determined under regulations prescribed by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services, or (3) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence.

An individual who is physically able but has a cognitive impairment such as Alzheimer's disease or another form of irreversible loss of mental capacity is treated similarly to an individual who is unable to perform (without substantial assistance) at least 2 activities of daily living. Because of the concern that eligibility for the medical expense deduction not be diagnosis-driven, the provision requires the cognitive impairment to be severe. It was intended that severe cognitive impairment mean a deterioration or loss in intellectual capacity that is measured by clinical evidence and standardized tests which reliably measure impairment in: (1) short- or long-term memory; (2) orientation to people, places or time; and (3) deductive or abstract reasoning. In addition, it was intended that such deterioration or loss place the individual in jeopardy of harming self or others and therefore require substantial supervision by another individual.

A licensed health care practitioner is a physician (as defined in sec. 1861(r)(l) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury. A licensed social worker includes any social worker who has been issued a license, certificate, or similar authorization to act as a social worker by a State or a body authorized by a State to issue such authorizations.

## I. Reporting Requirements

A payor of long-term care benefits (defined for this purpose to include any amount paid under a product advertised, marketed or offered as long-term care insurance) is required to report to the IRS the aggregate amount of such benefits paid to any individual during any calendar year, and the name, address and taxpayer identification number of such individual. In addition, a payor is required to report the name, address, and taxpayer identification number of the chronically ill individual on account of whose condition such amounts are paid, and whether the contract under which the amount is paid is a per diem-type contract. A copy of the report must be provided to the payee by January 31 following the year of payment, showing the name of the payor and the aggregate amount of benefits paid to the individual during the calendar year. Failure to file the report or provide the copy to the payee is subject to the generally applicable penalties for failure to file similar information reports.

## II. LEGISLATIVE BACKGROUND

The present-law provisions relating to long-term care were added by H.R. 3103, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").[6]

Prior to the enactment of HIPAA, there were no explicit rules in the Internal Revenue Code relating to the tax treatment of long-term care insurance contracts or long-term care services. Prior and present law do provide rules relating to medical expenses and accident or health insurance. Prior to HIPAA, the extent to which these rules applied to long-term care insurance contracts or long-term care services was unclear.

The legislative history to HIPPA provides that the tax provisions relating to long-term care insurance contracts and long-term care services were adopted to provide an incentive for individuals to take financial responsibility for their long-term care needs. Thus, HIPPA generally provided favorable tax treatment with respect to long-term care insurance contracts and services meeting HIPPA's requirements.[7] Contracts or services that do not meet HIPPA's requirements continue to be subject to the prior-law rules.

[6] Pub. L. No. 104-191, signed on August 21, 1996. H.R. 3103 was reported by the House Committee on Ways and Means on March 25, 1996 (H.R. Rept. 104-496, Pt. 1), and was passed by the House on March 28, 1996. The Senate version of the bill was S. 1028, which was reported by the Senate Committee on Labor and Human Resources on October 12, 1995 (S. Rpt. 104-156). H.R. 3103, as amended, was passed by the Senate on April 23, 1996. The conference report was filed on July 31, 1996 (H.R. Rept. 104-736), and was approved by the House on August 1, 1996, and by the Senate on August 2, 1996.

[7] H.R. Rpt. 104-496, Pt. 1, at 115.